

NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER
NURSING DEPARTMENT

PROCEDURE: Physical Intervention with an Aggressive Patient

Approved:

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targeted grasps the patient's wrist. The other staff grasps the patient's other wrist.

6. The patient's arms are then brought to his side and then back until upright with palms up or forward. Elbows are locked, and shoulders are pushed down below patient's hip level. By pivoting and stepping in front of the patient, his forward momentum is then stopped. Staff use hips and thighs to hug inward towards each other, taking tiny steps forward. This reduces patient mobility and increases support.
 7. The third and fourth staff members assist to help maintain the patient's balance and confine his movements by holding the patient's belt or other article of clothing around his waist from behind, or pushing down on shoulders from the front.
 8. **AVOID, IF AT ALL POSSIBLE, TAKING THE PATIENT TO THE FLOOR.**
 9. Upon leader's command, both staff members, while holding the patient's arms, will shift from the control position to the walking upright position. Staff member to the rear will continue to help balance the patient by holding on to the belt or waist clothing.
 10. The patient is then walked briskly to the designated area.
 11. If patient requires immobilization during the walk, staff may shift hips further behind the patient and position patient's arms further behind his back. Then position the patient's arms closer to the body of the staff. The staff push against each other "back to back."
 12. If the patient is highly resistive, the team leader may command a take down and hold. The control/hold positions may be sufficient to manage the patient until his/her cooperation is achieved. When patient is more cooperative the upright transport method may be tried again.
Note: **If the patient continues to be resistive and the leader and team determines the patient cannot be safely walked to seclusion, the patient may be secured in four point locked leather restraints attached to a wheeled hospital bed and transported to seclusion.**
 13. The patient then is lowered prone to the floor in a "take down" technique. Staff should be as close to the patient's body as possible. Staff's hips should be
 6. Without using own muscle power, the staff member is controlling the patient by taking advantage of the patient's forward momentum. The full containment position reduces the opportunity to struggle or potentially loosen staffs' control position. The patient is dependent on the staff for balance and security.
 8. Statistically, this is when injuries most often occur.
 9. The preferred mode of moving the patient is the triangle team transport technique.
- Positional transitions are times of lessened staff control, thus any transition requires the team's organized attention on the leader.
11. Staff can also return to the more secure control position as necessary during transport.
 12. This method is to be used only when previous techniques fail. Statistically, most injuries occur during floor struggle.
 13. Every attempt must be made to maintain close

in contact with the patient's hips. Instruct pt. to kneel. Staff use hips and thighs to hug inward towards each other, taking tiny steps forward. The staffs' bodies act as a surface upon which the patient is gradually and safely lowered to the floor. The team members in the rear control the patient's legs. **AVOID ANY PRESSURE TO JOINTS, ESPECIALLY KNEES.** The patient is then held in a control position on the floor. Again, 3-4 staff members can control most patients.

proximity between staff members' and patient's hips: this position provides the stability necessary to lower the patient gradually and safely to the floor.

14. Staff should not be in a hurry to transport the patient. If indicated, medication may be given intramuscularly at this time. After the patient has calmed somewhat, he may be transported using the upright walk technique. Judge patient's ability to safely cooperate by gauging muscle relaxation, ability to listen and concentrate (e.g., ask patient to count backward from 5), and to follow simple instructions, (e.g., "Stop struggling.").
15. Transportation of the patient should be a steady movement--**DO NOT RUSH.**
16. In the seclusion room, lower patient to the mattress according to procedure #13. Legs are crossed at ankles.
17. Potentially dangerous objects are removed from patient's person (jewelry, shoes/laces, belts, sharps, etc.)
18. Leader directs each staff to release limbs: feet first, then arms one at a time in rapid succession.
19. Involved staff review the procedure immediately following the intervention.

14. With time, patients tire and may be more easily and safely transported.

18. If staff remaining lose control of patient, released staff return to floor control position.

19. Critical review session provides opportunity to evaluate efficacy of physical intervention and provides opportunity for professional expression of feelings evoked by aggressive behavior. As part of follow-up and therapeutic care planning, criteria for discontinuing seclusion or restraints are established now. The team identifies factors contributing to the patient's immediate and ongoing loss of control, and incorporates this assessment into preventative care planning.

C. Documentation

- See CCND Standard of Practice “Nursing Prevention and Management of Aggressive Behavior,” CCND Standard of Practice “Care of the Patient in Locked Seclusion,” CCND Standard of Practice “Management of the Patient in Type I Papoose Restraint (for Behavioral Health Children),” CCND Standard of Practice “Management of the Patient in Restraints,” as applicable.

D. References

1. CCND Standard of Practice “Nursing Prevention and Management of Aggressive Behavior” 1995, (revised 9/97, 9/98, 11/99).
2. CCND Standard of Practice: Management of the Patient in Restraints, Type I and II, 6/92, revised 11/96, 9/97, 9/98, 12/99, 10/00.
3. Clinical Center Policy and Communications Bulletin, Medical Administrative Series, M-94-10 (revised 26 September 2000). Subject: Restraint and Seclusion.
4. CCND Standard of Practice: Care of the Patient in Locked Seclusion, 1995, (revised 9/97, 9/98, 11/99, 10/00).
5. “Guidelines for Crisis Intervention: The Threatening or Violent Patient” MHAPLS Service Crisis Prevention Workshop Course Outline, 1992 (revised 1997).
6. National Crisis Prevention Institute: Nonviolent Crisis Intervention. Brookfield, WI. 1987.